MEMORANDUM

May 16, 2007

TO: THE LOS ANGELES COUNTY CLAIMS BOARD

FROM: GEORGE PETERSON, ESQ.
Peterson & Bradford

NARBEH BAGDASARIAN
Deputy County Counsel
Health Services Division

RE: **Nellie Molina, et al. v. County of Los Angeles**
Los Angeles Superior Court Case No. YC043883

DATE OF INCIDENT: June 13, 2001

AUTHORITY REQUESTED: $1,755,000 (45 percent of the total $3,900,000 settlement), and assumption of the Medi-Cal lien in the amount of $306,573.51 (45 percent of the Medi-Cal lien).

COUNTY DEPARTMENT: DEPARTMENT OF HEALTH SERVICES

CLAIMS BOARD ACTION:

☐ Approve ☐ Disapprove ☒ Recommend to Board of Supervisors for Approval

_____, Chief Administrative Office
ROCKY ARMFIELD

_____, County Counsel
JOHN F. KRATTLI

_____, Auditor-Controller
MARIA M. OMS

on May 29, 2007

HOA.442663.1

SUMMARY

This is a recommendation to settle for $1,755,000 (45 percent of the total $3,900,000 settlement), the medical negligence lawsuit brought by Raul Molina and Yvonne Molina, the parents of Nellie Molina, who suffered injuries after receiving care and treatment at Harbor/UCLA Medical Center ("HUMC"). As a part of the settlement, the County will assume the Medi-Cal lien in the amount of $306,573.51 (45 percent of the total Medi-Cal lien).

LEGAL PRINCIPLE

The County is liable for the failure of its hospital and medical staff to provide services consistent with the appropriate standard of care for the circumstances encountered.

SUMMARY OF FACTS

On June 12, 2001, Nellie Molina, a 1½-year-old female infant, was admitted to the Pediatric Cardiothoracic Surgery program at HUMC, to undergo surgery to repair a structural defect in her heart. The surgeon for this procedure was from UCLA, with surgical privileges at HUMC and covered by the County. The perfusionist (a person who operates the by-pass machine and monitors the patient's cardiovascular and respiratory condition during the operation), was provided by Edwards Lifescience Corporation ("Edwards"), an entity which had a contract with the County to provide perfusion services at HUMC. All the other personnel involved in the operation, including the anesthesiologist, were from HUMC.

The surgical procedure was performed on June 13, 2001. The surgical team initially attempted to repair the structural defect in the patient's heart. After the procedure was completed, diagnostic measures indicated that the defect was not completely repaired; therefore, the surgeon decided to proceed with a second attempt. The entire operation, thus, lasted longer than expected, and required two passes on the by-pass machine (where a machine pumps the blood in the patient's body as the surgeons operate on the patient's heart).

The protocol for pediatric by-pass procedures specifically requires cooling of the patient before the by-pass. In this case, the patient was in fact cooled, but only for the first surgical effort. No re-cooling took place for the second surgical effort. Arguably this was a failure by the perfusionist to follow the protocol. The perfusionist testified, however, that she did not re-cool the patient simply because the surgeon did not tell her to do so. The surgeon has testified that it was his responsibility to make sure the patient was re-cooled for the second repair.

During the operation, Nellie's Hematocrit (a measurable variable indicating blood's ability to carry oxygen) fell significantly below the normal acceptable levels for fifty minutes. It was the responsibility of the perfusionist to monitor and report the patient's Hematocrit to the surgeon during the operation. The records do not reflect whether the Hematocrit values were ever reported to the surgeon or the anesthesiologist. All of these shortcomings contributed to Nellie's subsequent hypoxic brain injury.

The anesthesiologist involved in the surgery has testified that he did not supervise the perfusionist's activities. Moreover, the records do not demonstrate any routine supervision by HUMC over the quality of perfusion services. The perfusionist has testified that there was no inquiry from HUMC regarding any quality control. Most importantly, no one looked at the accumulated perfusionist by-pass reports, to determine exactly what this particular perfusionist was doing in any of her cases prior to Nellie's operation.

After the conclusion of the surgical procedure, the patient was taken to PICU (Pediatric Intensive Care Unit). Although the personnel remember monitoring the patient, for about forty minutes, no one recorded any vital signs for the patient. Her last recorded temperature in the operating room was about 101 degrees; when she arrived at PICU, her temperature was 105.6 degrees. Once in the PICU, Nellie experienced further dramatic fluctuations in temperature, which rose the following morning to 107.1 degrees.

While in the PICU following the procedure, Nellie's blood pressure was initially low with erratic cardiac rhythms. She was relatively stable until five hours after her arrival in the PICU, when she had a cardiac arrest. As a result of the cardiac arrest, a distress call (code blue) was made to initiate immediate resuscitative efforts. The patient was resuscitated, but during this episode, she possibly suffered an additional shortage of oxygen to her brain.

Nellie was transferred to UCLA Medical Center on June 14, 2001, where she received further treatment for her condition. Diagnostic studies at UCLA confirmed that she had suffered a global hypoxic-ischemic event (due to lack of oxygen to her brain), and irreversible neurological injuries. After treatment at UCLA, Nellie was transferred to Pacifica Hospital and then to Rancho Los Amigos Rehabilitation Center.

Nellie is now 7½ years of age, and resides at home with her parents. She will need continuing attendant care for the rest of her life. She is now expected to live for another 20 to 25 years.

THE LAWSUIT

On August 6, 2002, a lawsuit was filed on behalf of Nellie, naming the County and Edwards as defendants. The lawsuit alleged that, during the June 13, 2001, heart surgery, the perfusionist failed to advise the surgeon that the patient's Hematocrit was dangerously low, causing her further complications resulting in severe brain damage. It further alleged that the County failed to properly supervise the perfusionist and to maintain a qualified surgical team to perform this type of sensitive and complicated surgery.

The County filed a cross-complaint against Edwards for indemnification. For the purpose of this settlement, Edwards agreed to pay 55 percent of the global settlement of $3,900,000, and assume 55 percent of the total Medi-Cal Lien, which is approximately $681,275.

DAMAGES

If this matter proceeds to trial, the plaintiffs will likely seek the following:

Pain and Suffering (MICRA Limit)	$ 250,000.00
Past medical expenses	$ 681,274.47
Future medical expenses	$10,000,000.00
Loss of Earnings (past and future)	$ 637,000.00
TOTAL	$11,567,274.47

The proposed settlement includes:

Pain and Suffering	$ 250,000.00
Medi-Cal lien	$ 306,573.51
Future medical care	$1,006,350.00
Future wrongful death (for parents)	$ 100,000.00
Attorneys' Fees (MICRA limitation)	$ 323,650.00
Costs of Litigation (estimate)	$ 75,000.00
TOTAL	$2,061,573.51

STATUS OF CASE

Nellie's parents filed this medical malpractice lawsuit on her behalf. This matter involves medical issues surrounding the care and treatment rendered to Nellie at HUMC. The current trial date has been vacated pending approval of this settlement.

The County's attorneys' fees and costs to date are approximately $1,448,670 ($914,566 for attorneys' fees and $534,101 for costs). The litigation has been expensive because of the number of medical experts who were hired to review this case, the number of pleadings and motions (over 45) that were filed and litigated by the parties in this case, and the fact that the County had to repeatedly consult appellate counsel to evaluate and analyze various complicated legal and discovery issues that arose during the course of this litigation. We have exercised close supervision over our outside counsel's case evaluation plans and budgets.

Although the County had met and discussed settlement with the plaintiff's attorney and Edwards' general counsel, no earlier settlement could be reached because the plaintiff's counsel repeatedly changed his position and demand, and because Edwards did not offer its full settlement authority to settle this case.

The total cost to the County as a result of this settlement is as follows:

Indemnity (County's share of Settlement)	$1,755,000.00
Medi-Cal lien (County's share)	$ 306,573.51
County Attorneys' Fees and Costs	$1,448,667.75
TOTAL	$3,510,241.26

EVALUATION

Medical experts will be critical primarily of the County's failure to provide adequate perfusion services. This failure fell below the standard of care and contributed to the injuries suffered by Nellie Molina. Eight roundtables were held in this case, and it was the consensus of the participants that this is a liability case and as such, should be settled. The proposed settlement is within the parameters discussed and agreed to at the roundtables.

The Board of Supervisors has been previously advised of this case and its settlement. (Please see attached memoranda.) We join with our private counsel, George Peterson, Esq., and our claims administrator, Sedgwick Caronia, in recommending settlement in the amount of $1,755,000 and assumption of the Medi-Cal lien in the amount of $306,573.51.

The Department of Health Services concurs in this settlement.

APPROVED:

RICHARD K. MASON
Assistant County Counsel